[redacted]

RESULT REVIEW REPORT
HUNTSVILLE HOSPITAL
101 SIVLEY ROAD
HUNTSVILLE, AL 35801

[redacted]

Age: 56 Sex: M [redacted]

[redacted]

Ordering Provider:

Type: TRX

>>>> HPI: History obtained from patient and Nurses Notes
Weakness - Onset 3days ago. Weakness to right side arm more than leg---affected walking ---right handed , (-)slurred speech, (-)facial drooping, (+)difficulty walking, (-)recent bleeding, (-)vomiting, (-)Diarrhea.
>>>> PMH List (See PMH Table) . Pt last seen without neuro deficit at type in. Pt developed a sudden and constant onset of neuro symptoms: Last Known Well Verified
Associated Symptoms: (+)headache, right side (-)seizure, (-)head injury, (-)fall, (-)trauma, (+)altered mental status, only fuzzy headed and wife says completely oriented (-)disoriented, (-)confused, (-)agitated, (-)difficulty concentrating/thinking, (-)decreased responsiveness, (-)unresponsive, (+)difficulty standing/walking, (-)neck pain, (-)nausea, (-)vomiting,(-)bedridden. Symptom(s) are stable for these 3 days and similar problems over the past 6 mos . CVA last Sept--tx at HH. Caused syncope. Scan was abnormal. Saw neuro who agreed was a stroke. Only problem then was right sided weakness. and are mild in context. Baseline status: alert and oriented, and walks without assistance. 2 weeks ago and last Th near syncope. right arm completely but briefly numb

( )Symptoms worsened by nothing.
( )Symptoms improved by nothing.
no prior hx of similar problem.
( ) Patient was recently treated/seen by Physician type in. ( )Recent hospital admission.
>>>> PREHOSPITAL CARE: See Nursing Notes.
>>>> ROS: (+)unsteady gait, ( )dizziness, (-)visual changes, ( )sore throat, (-)cough, (-)chest pain, (-)palpitations, (-)dyspnea, (-)abdominal pain, (-)diarrhea, (-)bloody stools, (-)dysuria, (-)fever, (-)rash, (+)joint pain, pain right hip--chronic (-)exposure to insect bite, (-)exposure to tick bite, (+)all other systems negative.
>>>> LMP:
>>>> LNMP:
>>>> PMH List (See PMH Table)
>>>> PSH List (See PSH Table)
>>>> FH: ( )DM, ( )HTN, ( )cancer
>>>> PSYCH SOCIAL: ( )tobacco, ( )alcohol, ( )drugs
>>>> VITALS: ( )Nurse's Note Reviewed, ( )Febrile, ( )Tachycardia, ( )Hypotensive, ( )Hypertensive
>>>> PHYSICAL EXAM: Physical Exam not limited
GENERAL APPEARANCE: well nourished, level of consciousness, no acute distress, no obvious discomfort.
MENTAL STATUS: speech clear, oriented X 4, normal affect, responds

[redacted]

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appropriately,
NEURO: normal gait, ( )hypotonia, (+)ataxia, ( )cerebellar function intact, cranial nerves II - XII intact, claims weakness right arm moreso than leg but difficult to demonstrate , sensory intact,
HEAD: (-)swelling, (-)tenderness
EYES: no ptosis, PERRL, EOMI, conjunctiva clear.
NOSE: no nasal discharge.
MOUTH: (-)decreased moisture, no lacerations inside mouth.
THROAT: no airway obstruction.
NECK: (-)carotid bruit bilateral, (-)nuchal rigidity, no neck tenderness, (-)thyromegaly.
BACK: no back tenderness.
LUNGS: (+)lungs clear, no wheezing, no rales, no rhonchi, (-)accessory muscle use.
HEART: normal rate, normal rhythm
ABDOMEN: normal BS, soft, no abd tenderness, (-)guarding, (-)rebound, no organomegaly, no abd masses.
RECTAL:
EXTREMITIES: (-)swelling, (-)tenderness pain right hip with movement
SKIN: (-)ulcers, warm, dry, good color, no rash.
>>>> DIFFERENTIAL Dx: During the assessment and evaluation, the following were considered.
NEURO Dx:
>>>> RESULTS REVIEWED:
Laboratory:
ALL LABS: unremarkable.
Radiology: nl CXR CT brain--NAD per rad
#1 EKG(my reading): nsr at 66 normal
Rhythm Strip:
Other:
Pulse Ox:
( )Nursing Notes Reviewed
Old Records not reviewed. sept 11 charting- [redacted] was neuro and CT showed frontal lobe ischemic stroke. On revisit to hospital with similar symptoms pt was thougt to be have panic attacks .
>>>> ED COURSE:
>>>> MEDICATIONS FLUID RESUSCITATION:
>>>> PAIN MANAGEMENT:
>>>> RESPIRATORY CARE:
>>>> PROCEDURE:
>>>> DISPOSITION:
>>>> STROKE CARE: ( )Stroke Alert Called, ( )ASA given per Stroke Protocol, ( )IV Fluid Bolus given per Stroke Protocol, ( )Patient instructed to remain supine, ( )Patient sent for Head CT.
>>>> CRITICAL CARE TIME: not requested

[redacted]

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Ordering Provider:

Type: TRX

4mm and reactive, Conjugate gaze
THROAT: no airway obstruction.
MOUTH: (+)tongue midline, (-)facial droop left, secretions: maintaining secretions
SWALLOWING ASSESSMENT; (+)Swallows without difficulty, (-)Unable to swallow, (-)Deferred due to patient condition
NECK: (+)supple, (-)rigid, (-)not assessed due to spinal precautions
RESPIRATORY: no wheezing, no rales, no rhonchi, (-)accessory muscle use, good air exchange bilateral.
GASTROINTESTINAL: normal BS, soft, no abd tenderness, (-)nausea, (-)vomiting, (-)OG/NG tube placement confirmed, remains to intermittent low wall suction
CARDIOVASCULAR: rate 60, normal rhythm
NEURO: hands grips equal, plantar/dorsiflexion equal, Babinski absent, no pronator drift, sensory intact, Posturing - None Noted
GLASGOW COMA SCORE: - (adult) - eyes open spontaneously 4, verbal converses and oriented 5, motor obeys commands 6, glasgow coma total 15.
MENTAL STATUS: speech clear, normal affect, responds appropriately, oriented X 4 .
GENERAL APPEARANCE: alert and oriented, no acute distress, no obvious discomfort.
SEIZURE: ( )yes, (+)no,

///*** ATTN: 126 STRUCK-THROUGH CHARACTERS NOT SHOWN HERE ***///

[redacted] Created: 10/1/2012 9:13pm Last Entry: 9:14pm

Nurse Note:
ADMISSION (on Monitor) Patient prepared for transport to bed# 834B 8MST (Neuro Spine) and admitted to service of [redacted] Admission orders were received. Nursing report provided to [redacted] RN using SBAR format. Patient belongings: See valuable sheet. Transport to floor on cardiac monitor and O2 with nurse.
IV Fluids and/or Medications Continued on Admission: (-)Yes, (+)No.
Restraints continued on admission: (+)Not Applicable, (-)Yes, (-)No
Intake Output (See Table)

[redacted] Created: 10/1/2012 3:55pm Last Entry: 9:29pm

PHYSICIAN H&P (NEURO DEFICIT)
>>>> History not limited
Transferred from: Not transferred PMD---[redacted]

[redacted]

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Type: IRX

[redacted] Created: 10/1/2012 4:40pm Last Entry: 4:46pm

Physician Note: Pt stands to walk but is quite unsteady and feels as though he is going to fall. Pt wishes admission.

[redacted] Created: 10/1/2012 5:37pm Last Entry: 5:39pm

Physician Note: discussed with UAB INT MED who will come to evaluate the patient. [redacted] is on call for neuro and [redacted] is his neuro so have not discussed with neuro yet. Will await IM eval

Orders

Orders (MDM)

Order	Sched D/T	In Prog D/T	Comp D/T	MD
Saline Lock	10/1/2012 3:28pm	10/1/2012 3:43pm	10/1/2012 3:33pm	Cr M. 3:
Cardiac Monitor w/ Rhythm Strip	10/1/2012 3:28pm	10/1/2012 3:43pm	10/1/2012 3:33pm	Cr M. 3:
Continuous pulse oximetry	10/1/2012 3:28pm	10/1/2012 3:43pm	10/1/2012 3:33pm	Cr M. 3:
Oxygen 2L per NC	10/1/2012 3:28pm	10/1/2012 3:43pm	10/1/2012 3:33pm	Cr M. 3:
EKG Electrocardiogram	10/1/2012 3:28pm	10/1/2012 3:37pm	10/1/2012 3:33pm	Cr M. 3:
CBC WITH DIFF (CBC/DIFF)	10/1/2012 3:28pm		10/1/2012 3:51pm	Cr M. 3:
BMP	10/1/2012 3:28pm		10/1/2012 4:13pm	Cr M. 3:
CREATINE KINASE WITH ISOENZYMES	10/1/2012 3:28pm		10/1/2012 4:14pm	Cr M. 3:
TROPONIN T, SERUM	10/1/2012		10/1/2012	Cr

[redacted]

[redacted]

HISTORY AND PHYSICAL

[redacted]

Date of Birth: 02/04/1957

Date of Admission: 10/01/2012 Patient Type: Outpatient

[redacted]

Primary care physician is [redacted] Emergency room physician was [redacted]

CHIEF COMPLAINT: Dizziness and lightheadedness.

HISTORY OF PRESENT ILLNESS: The patient is a 55-year-old white male with a past medical history of cerebrovascular accident (frontal ischemic stroke one year ago), and hyperlipidemia, presented with six months to 1 year history of sensation of dizziness and lightheadedness lasting 1-2 minutes, and occurring 7-8 times per day. These episodes occur usually while he gets up from sitting posture and while walking, but not associated with change in position of his head. He also complains of ringing sensation in his ears and decreased hearing in both ears. The dizziness is associated with palpitations, diaphoresis, shortness of breath, choking sensation, tingling and numbness in the extremities, more on the right side along with headache. The patient has been evaluated by cardiologist and neurologist a year ago, and ENT surgeon two months ago. His cardiology workup was completely normal and ENT examination was also normal. An MRI done in September 2011 showed left frontal ischemic stroke. Patient was advised to take aspirin and Pravastatin, which he stopped taking after a short while. Patient was also advised to use Meclizine for his dizziness, which he stopped as it did not help him. His decreased hearing is attributed to occupation as a machine operator, but uses ear plugs while working with his machines. Patient also complains of right hip pain while getting up and is due to an orthopedic consultation in the following week. Recent hospitalization was in Huntsville Hospital in September 2011 with a diagnosis of cerebrovascular accident and possible panic attack.

PAST MEDICAL AND SURGICAL HISTORY:

1. Cerebrovascular accident, left frontal and frontoparietal ischemic stroke in 2011.
2. Hyperlipidemia.
3. Patent foramen ovale.
4. Nephrolithiasis with lithotripsy in the past.
5. Left hip replacement 2 times and right hip pain, waiting consultation by orthopedic surgeon in the following week.

SOCIAL HISTORY: Patient is currently working as a heavy machine operator and is married and lives with his wife. He drinks alcohol socially, but denies tobacco use or illicit drug use.

[redacted]

[redacted]

[redacted]

MEDICATIONS: Patient is not known to be allergic to any medication. Patient is not currently on any medication.

FAMILY HISTORY: Mom has diabetes mellitus, hypertension and unknown cancer. Dad died of coronary artery disease after the age of 80 years.

REVIEW OF SYSTEMS: Positive for dizziness, vision blurring with dizziness, decreased hearing, tinnitus, postnasal drip, shortness of breath, palpitations, decreased flow of urine secondary to prostate enlargement, right hip joint pain, weakness, numbness and tingling on the right upper extremity, headache and anxiety. The rest of the review of systems is negative.

PHYSICAL EXAMINATION: Temperature 98.3, heart rate 69, respirations 17. Blood pressure: Patient's orthostatic vitals were checked which showed blood pressure lying 143/95, sitting 147/94 and standing 130/112. Patient is saturating 100% on 2 liters of oxygen by nasal cannula.

GENERAL EXAMINATION: The patient was in stable condition, resting comfortably in bed. He is awake, alert, and oriented x 4.

EYES/EARS/NOSE EXAMINATION: EOMI, PERRLA. No icterus or pallor. Tympanic membranes are normal. External auditory meatus and canals are normal. Nose is normal.

MOUTH/THROAT/NECK: Tongue is moist. Throat is clear. Neck is supple No palpable mass. No JVD and no carotid bruit.

CARDIOVASCULAR SYSTEM: S1 and S2 heard normal. Regular rate and rhythm. No murmurs, gallops or rubs.

RESPIRATIONS: Clear to auscultation bilaterally. Air entry is equal in both lung fields.

GASTROINTESTINAL: Bowel sounds are present. It is soft, nontender and not distended. No organomegaly.

MUSCULOSKELETAL: Good tone and strength. Right hip pain on flexion is present.

SKIN: Warm and dry and intact. No rash or scars.

EXTREMITIES: No edema, no clubbing, no cyanosis. Peripheral pulses 2+ bilaterally. Gait is normal. Romberg is negative.

NEUROLOGIC EXAM: Cranial nerves are intact. Reflexes are 2+ bilateral. Strength is 5/5 in all extremities No sensory deficit.

INVESTIGATIONAL DATA: White blood cells 4.98, hemoglobin 16, hematocrit

[redacted]

[redacted]

[redacted]

46.8, platelets 234. Sodium is 140, potassium 4, chloride 104, bicarbonate 29, BUN 9, creatinine 0.9, blood glucose 102 and serum calcium 9.9. PT 13.4, INR 0.9. Troponin-T is less than 0.01. CPK 39, CK MB 3.4. EKG: Normal sinus rhythm. Chest x-ray: No acute process is noted. CT head without contrast: No acute intracranial process is noted.

ASSESSMENT AND PLAN:

1. Dizziness and lightheadedness with no associated weakness or neurologic deficit. Although patient has a past history of cerebrovascular accident, patient's current symptoms of 6 months to 1 year duration are less likely to be TIA, but patient's symptoms are associated with palpitations, diaphoresis, shortness of breath, choking sensation, visual dimming. The possible etiology can be anxiety attack versus vasovagal syncope while vasovagal syncope may be triggered by his right hip pain. Patient is known to [redacted] cardiologist, so we will consult cardiologist to rule out cardiac cause.
2. Patient's symptoms are associated with tinnitus and decreased hearing, possibility of Menlere's disease. We will check for TSH and VDRL, and if necessary, we will consult ENT.
3. Patient's EKG is normal sinus rhythm and had extensive cardiac workup in the past, which was normal, and also patient's orthostatic vitals in the emergency room were normal. We will repeat patient's orthostatic vitals in order to rule out orthostatic hypotension as a cause of his dizziness.
4. Patient is currently not taking any medication, which is known to cause dizziness or tinnitus, so we will order UDS to exclude any drug contributing for his dizziness.
5. Right hip pain with scheduled appointment with orthopedics the following week. We will give him Tylenol to control his pain.
6. Decreased hearing probably secondary to occupation as heavy machine operator. We will advise the patient on preventing exposure to loud noises by wearing proper protection and to have regular ENT check.
7. Hyperlipidemia. We will order lipid panel and treat if necessary.
8. Since patient is not seen by a neurologist in the past, we will call for a neurology consult to exclude brainstem as the cause of his dizziness.

[redacted]

D: 10/02/2012 08:06 P
T: 10/03/2012 05:49 A

[redacted]

[redacted]